Dear Steering Committee Members

As you prepare to meet on May 27. I would like you to consider the 3 following points in making budget plans for FY2011. Economics of Scale, Health Status and Disadvantages of Rural Areas, Assumptions of local agencies who stepped up to be a Lead Agency.

Part of the American Health Association Agenda for Health Reform of 2009 was to "**improve the distribution and diversity of health professionals in medically underserved communities".** This includes goals to "**develop, expand and monitor programs to reduce disparities in health"**. Persistent health inequities and disparities mean that millions of Americans suffer from a disproportionately high burden of disease, disability and premature death. The vision of the American Public Health Association is to 'Improve the health of the public and achieve equity in health status.' ***The current funding formula for Montana WIC is in direct opposition to these goal.***

Rural Montanans suffer health disparities due to being geographically disadvantaged. Lack of services in small communities impacts long term health and wellness of its citizens. I have included an attachment for statistics of all counties in Montana taken from the 2009 Kids Count Data book. You will note that in smaller counties the incidence of low birth weight, infant mortality and teen births are consistently higher than the state average. The percent of women receiving prenatal care is lower than the state average as is the mean income.

1. Economics of scale.

Prior to FY 2007 - Flat funding rate was changed to funding bands by a funding committee of local agency representatives. The committee decided that larger clinics did not incur as high of an expense ***after a certain client level*** – economics of scale. (There are set expenses for rent, utilities, etc… regardless of client load)

The FY 2009 budget funded all clinics at **a set rate based on total participation**. This was a great benefit to the larger clinics at the expense of the smaller ones. This makes continuing hold a WIC clinic in the rural communities of Montana more of a challenge or impossible. In addition the 2010 budget had a decrease in per participant of – $8.70 (FY2009 base rate per participant 181.71, FY2010 Base rate per participant $173.01)

In addition each Region was given base rate of **$2000 (increased to $4000 in FY 09)** without regard to the number of local clinics served. (The five regions with just 1 clinic received the same funding as the 3 regions with 6 or more clinics). Obviously it costs more to just open the doors at multiple clinics and this does not consider travel costs to get there

If small clinics are closed due lack of funding the participation level will continue to decline due

to:

- Cost of fuel – a round trip from Broadus to Miles City has a fuel cost of $20.00. This is taking for granted that the family has a reliable transportation for the 165 mile round trip with reasonable fuel economy.
- In addition the wage earner would be required to take the whole day off work to make the trip rather than coming over break or noon hour.
- This is a major barrier to service for rural communities

2. Health Status and Disadvantages of Rural Areas

Larger towns are already at an advantage of having more resources and decreased distance for service. A workshop at the 2009 State Public Health Meeting showed that **women in the Eastern Region of Montana – (East of Billings) had almost 30% higher incidence of Gestational Diabetes and Obesity** of any other region in Montana. Small counties as stated above also have higher incidents of high low birth weight, infant death and teen pregnancy along with later prenatal care and lower mean income than the state average. Yet WIC funding has made quality services next to impossible to this highest risk population. Providing multiple months of vouchers and service over the phone is no substitute for personal face to face attention at the local level.

WIC funding the past two years has decreased so that there are fewer towns with clinics or have towns have decreased service. Ekalaka no longer has local service – must travel 45 miles to Baker. Garfield County was closed for almost a year and now only has local WIC clinic every 3 months, or participants must travel 85 miles to Miles City or Glendive this makes it difficult to start new clients. The Petroleum County Clinic has been discontinued. Missoula WIC-closed their offices in both Frenchtown and Phillipsburg. Satellites have closed within cities in Great Falls, and Billings as well.

3. False Seduction of Lead Agencies by Implied

Local WIC agencies who accepted the challenge of Lead Agency did so with the understanding that there would be funds planned in the budget for the added responsibilities. The budgets have reflected this up until the FY2008 proposal. FY2005, 2006, and 2007 provided Lead Agency Funding of $1588.00 per allied county with greater than 30 participants and $794.00 per allied county of less than 30 participants. Budget FY2009 and FY2010 replaces the Lead Agency Funds with a Regional Dollars/**(s)** amount of **$4000.00** given to all regions **without regard to the number** of allied counties.. As the lead agencies take on additional duties previously the responsibility of the state, there should be a commensurate transfer of operating funds to the local lead agencies. The cost to fulfill these duties is based on the number of allied counties served, and distance from the Lead Agency, not the number of clients.

- With regionalization **original lead agencies were offered a stipend for each affiliated county.** This amount has been reduced with the current 08 budget.

- Custer County – For Example
    - FY 06 – had 4 counties – lead agency total stipend was $4,764.00
    - **FY – 07 had 7 counties – lead agency total stipend was $8,734.00**
    - FY – 08 – had 7 counties – Regional step bonus $2,100.00

- **FY-10 – have 7 counties – Regionl Lead support $4,000.00**

- Why would Custer County want to continue to be the lead agency for these other counties when there is not equitable funds to support the extra work
- There is no incentive to consider aligning with any other groups at this point
- Distances to clinics is a barrier to service if this funding forces closure of smaller clinics

Cost to be a lead agency – has been restructured to be based on number served in the aligned counties not the number of counties. True cost is based on:

- Number of counties or sites served not the total clients-
  - state office sends supplies, memo's etc and expects lead to ensure all local clinics get them.
  - There is additional bookkeeping and accounting required for each local contract
  - Lead is required to monitor each contract separately regardless of number of participants at that local site
- Distance of county from lead agency
- If the aligned county has an RD on staff
- If aligned county has a qualified breastfeeding coordinator

Please consider funding lead agencies with a slightly higher rate for the first 500 participants and based on the number of counties served. Provide funds to support travel to the outlying clinics in order to keep with the American Public Health goals to "**improve the distribution and diversity of health professionals in medically underserved communities".** to "**develop, expand and monitor programs to reduce disparities in health.**

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